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Supreme Court, U.S.
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No. 08-

IN THE

Supreme Court of the United States

MARTHA BELL,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

I. Whether the conviction for health care fraud must be reversed because a medicare/medicaid certification is not money or property under the reasoning set forth in *Cleveland v. United States*, 532 U.S. 12, 121 S. Ct. 365, 148 L. Ed. 2d 221 (2000)?

II. Whether convictions for making false statements to conceal allegedly substandard medical care must be reversed because there is no clear definition of what constitutes substandard medical care?

III. Whether the decision of the court of appeals regarding the alleged *Brady* violation conflicts with the decisions of this Court and other courts regarding the government's obligation to disclose impeachment evidence in the possession of law enforcement?

LIST OF PARTIES

Petitioner: Martha Bell.

Respondent: United States of America.

The appeal of Atrium I Nursing and Rehabilitation Center was withdrawn.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED FOR REVIEW ...	i
LIST OF PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF CITED AUTHORITIES	iv
OPINIONS BELOW	1
STATEMENT OF JURISDICTION	1
CONSTITUTIONAL, AND STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	4
STATEMENT OF THE FACTS	6
REASONS FOR GRANTING THE PETITION	16
CONCLUSION	28
APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT FILED JUNE 6, 2008 ...	1a

TABLE OF CITED AUTHORITIES

Page

CASES

Banks v. Dretke,
540 U.S. 668, 124 S. Ct. 1256,
157 L. Ed. 2d 1166 (2004) 25

Brady v. Maryland,
373 U.S. 83, 83 S. Ct. 1194,
10 L. Ed. 2d 215 (1963) 5, 24

Cleveland v. United States,
532 U.S. 12, 121 S. Ct. 365,
148 L. Ed. 2d 221 (2000) .....i, 17, 18, 22

Gonzales v. Oregon,
546 U.S. 243, 126 S. Ct. 904,
163 L. Ed. 2d 748 (2006) 22, 23

Kyles v. Whitley,
514 U.S. 419, 131 L. Ed. 2d 490,
115 S. Ct. 1555 (1995) 25

McNally v. United States,
483 U.S. 350, 97 L. Ed. 2d 292,
107 S. Ct. 2875 (1987) 17

United States v. Diaz,
2008 U.S. Dist. Lexis 19171 (S.D. FLA. 2008) 10

United States v. Lucien,
347 F3d 45 (2d Cir. 2003) 9

Cited Authorities

	Page
United States v. Marmelstein, 487 F. Supp. 2d 242 (EDNY 2007)	10
United States v. Scheer, 168 F.3d 445 (11th Cir. 1999)	24
United States v. Soliman, 2008 U.S. Dist. Lexis 50307 (W.D.N.Y. 2008) .	10
Youngblood v. West Virginia, 547 U.S. 867, 126 S. Ct. 2188, 165 L. Ed. 2d 269 (2006)	26
CONSTITUTIONAL PROVISIONS	
Fifth Amendment, U.S.C.A. 5	2

OPINIONS BELOW

On June 6, 2008, the Court of Appeals for the Third Circuit affirmed the judgment in a criminal case. Appendix "A."

On October 27, 2006, the district court imposed concurrent terms of sixty (60) months' imprisonment and three (3) years' supervised release.

On November 18, 2005, the district court denied the motion for judgment of acquittal by written order.

On April 12, 2006, the district court denied a motion for reconsideration.

On May 16, 2006, the district court denied a motion for a new trial.

STATEMENT OF JURISDICTION

The district court had jurisdiction pursuant to 18 U.S.C. § 3231. The court of appeals had jurisdiction pursuant to 28 U.S.C. § 1291. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1)

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Constitutional provisions

The Fifth Amendment reads, in pertinent part, as follows:

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury . . . nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty or property, without due process of law . . .

Statutory provisions

18 U.S.C. § 1347 Health care fraud

Whoever knowingly and willfully executes or attempts to execute, a scheme or artifice—

> (1) to defraud any health care benefit program; or,
>
> (2) to obtain, by means of false, or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the

delivery of or payment for health care benefits, items or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title [18 USCS § 1365]), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if any violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

18 U.S.C. § 1035. False statements relating to health care matters

Whoever, in any matter involving a health care benefit program, knowingly and willfully—

(1) falsifies, conceals, or covers up by any trick, scheme or device a material fact; or

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false writing or document knowing the same to contain any materially false, fictitious or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services, shall be fined under this title or imprisoned not more than five years, or both.

18 U.S.C. § 24

> (b) As used in this title, the term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item or service is provided to any individual or entity who is providing a medical benefit, or service for which payment may be made under the plan or contract.

STATEMENT OF THE CASE

On August 24, 2004, the Office of the United States Attorney for the Western District of Pennsylvania filed an indictment charging Martha Bell, and Atrium I Nursing and Rehabilitation Center ("Atrium I" or "Atrium"), a non-profit corporation, with one count of health care fraud (Count One) in violation of 18 U.S.C. § 1347 and 18 U.S.C. § 2 and ten counts of making false statements in connection with the delivery of health care services in violation of 18 U.S.C. § 1035(a)(2).

According to the indictment, Martha Bell and Atrium I knowingly and willfully executed and attempted to execute a scheme and artifice to defraud Medicare and Medicaid, and to obtain, by false and fraudulent pretenses, representations and promises, money under the control of such health care benefit programs, in connection with the delivery of and payment for health care benefits, items and services.

The indictment alleged that Martha Bell and Atrium I: (1) falsely represented that the required care, services

and environment would be provided to residents; (2) failed to provide such care, services and environment, and (3) falsely represented that these requirements had been satisfied.

On July 19, 2005, trial commenced before United States District Court Judge Terrence F. McVerry and a jury. At the close of the government's case, Ms. Bell and Atrium I presented motions for judgment of acquittal pursuant to Rule 29(a) F.R.Crim.P. On August 11, 2005, the District Court denied the motions.

On August 24, 2005, the jury convicted Ms. Bell on Counts One, Two, Three, Four, Five, Six, Eight, Ten and Eleven; Atrium I was convicted on all Counts.

Ms. Bell and Atrium I filed a timely motion for judgment of acquittal pursuant to Rule 29(c) F.R.Crim.P. The district court denied the motion.

Ms. Bell and Atrium I filed a motion for a new trial pursuant to Rule 33 F.R.Crim.P. alleging suppression of material favorable to the defense in violation of ***Brady v. Maryland***, 373 U.S. 83, 83 S. Ct. 1194, 10 L. Ed. 2d 215 (1963). On May 16, 2006, the District Court denied the motion.

On October 27, 2006, the District Court imposed a sentence of sixty (60) months imprisonment and three (3) years supervised release.

On June 6, 2008, the Third Circuit Court of Appeals affirmed in an unpublished non-precedential opinion. ***United States v. Martha Bell***, No. 06-4648.

STATEMENT OF THE FACTS

A. THE GOVERNMENT'S CASE

Atrium I was a skilled nursing facility specializing in the care of patients afflicted with Alzheimer's disease. The facility was located in Allegheny County, Pennsylvania. Martha Bell was a registered nurse, and a director and administrator of Atrium I.

Atrium I received 70% of its revenue from Medicare Part A ("Medicare") and Medicaid ("Medicaid"). Medicare provided federally funded payments for up to 100 days of skilled nursing home care that followed a qualifying hospital stay. Prior to 1999, Atrium I received Medicare reimbursement for costs incurred. Beginning January 1, 1999, Medicare payments to Atrium were based on a formula, which calculated a per diem rate for each patient. The per diem rate, adjusted on a yearly basis, ranged from approximately $120.00 to $480.00/ day.

Medicaid provided joint federal and state funding for nursing home patients whose income and resources were insufficient to meet the costs of necessary medical services. Such payments were made, without time limitations, based on a formula, which was determined using a per diem rate applicable to each nursing home facility. The per diem rate was adjusted on a quarterly basis, which ranged from approximately $133.00 to $145.00/day.

Medicare was administered by the Center for Medicare and Medicaid Services ("CMS"), an agency of

the Department of Health and Human Resources ("DHHR"). Medicaid in Pennsylvania was administered by the Pennsylvania Department of Public Welfare ("DPW"). CMS contracted with intermediaries, such as Veritus Medicare Services, and DPW, to provide claims processing and cost reporting services. In Pennsylvania, CMS delegated to the Department of Health ("DOH") the responsibility for inspection of nursing homes in connection with Medicare, while DPW delegated this responsibility to DOH in connection with Medicaid.

Since November 21, 1995, Atrium I was certified as a Medicare and Medicaid provider and subject to compliance with various regulatory schemes. Atrium I was required to comply with Medicare and Medicaid regulations, and to maintain records sufficient to disclose the nature of care provided to residents. Pennsylvania regulations (28 PA Code 211.5) required all nursing homes to create and maintain clinical records, including all information necessary to fully disclose the nature of services provided to nursing home residents, and to keep the records for a period of seven years after the resident's discharge or death. Federal regulations (42 C.F.R. 483.75(1)) required each facility to maintain complete and accurate clinical records for each resident for a period of five years from the date of discharge.

The DOH conducted surveys at nursing homes, including Atrium I, on an annual basis and also in response to any complaints, in order to ensure that Medicare and Medicaid regulations were followed and that residents were receiving adequate and proper care. CMS and DPW relied upon DOH surveys to determine whether nursing homes were in compliance with

regulations and eligible to receive Medicare and Medicaid funds. The surveys could result in deficiency citations by DOH and CMS leading to enforcement actions ranging from fines and civil penalties to a ban on admissions, loss of license and decertification from the Medicare and Medicaid programs.

The DOH relied on nursing home records, including those prepared and maintained by Atrium I, in conducting surveys, evaluating residents' care and determining whether to cite deficiencies.

The government presented witnesses to show that the employees of Atrium falsified records as follows: admission records (making it appear that Cecilia Cheke had bruises and sores at the time she returned from the hospital); nursing notes (a doctor's order was changed with respect to Helen Burge to make it appear that lab work was done in a timely manner); medication administration records ("MAR"), intake/output records ("IO"), concerning hydration of residents; weight measurements; Activities of Daily Living ("ADL") forms; records for DOH surveys. Residents' charts were withheld from DOH surveyors until they were fixed. False information and false records were given to investigators regarding when employees were on duty. Original records were removed from medical files. At times, staffing was below the optimum. Vendors' bills were not paid while Ms. Bell and Warren Mason were overpaid.

The government also presented evidence that a certified nurses' aid ("CNA") was directed by Ms. Bell to make false statements regarding the observations of

Mabel Taylor. The statements were made three days after Mabel Taylor's death and four days after she had stopped receiving Medicaid.

Evidence was submitted to show that a doctor's note as to Arlene Wastchak was falsified. Evidence was presented concerning the removal and replacement of a doctor's note from the file of Margaret DeSalle. Evidence was submitted to show that there were falsified IO forms making it appear as if Helen Fisher had received hydration flushes. Testimony also was presented that someone put the initials "BH" on ADL forms, which Elizabeth Hines claimed was a forgery of her initials.

B. THE CASE DOES *NOT* INVOLVE OVERBILLING

In the year 1996, Congress enacted the latest in a series of health care fraud statutes making any fraud perpetrated against a public or private payer a federal criminal offense. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 242(a)(1), 110 Stat. 1936, 2016 (1996).

As of the year 2003, case law interpreting the 1996 federal health care statute was "virtually non-existent." ***United States v. Lucien***, 347 F.3d 45, 48 (2d Cir. 2003)[applying the statute to scheme to defraud based on participation in staged accidents].

As of the year 2008, case law interpreting that statute all appear relatively well confined to a pattern of facts involving overbilling for professional services

or stereotypical insurance fraud. ***United States v. Marmelstein***, 487 F. Supp. 2d 242 (E.D.N.Y. 2007) [ophthalmologist billed for services not rendered or unnecessary], ***United States v. Diaz***, 2008 U.S. Dist. Lexis 19171 (S.D. Fla. 2008)[submission of false claims to Medicare], ***United States v. Soliman***, 2008 U.S. Dist. Lexis 50307 (W.D.N.Y. 2008)[physician submits false claims to Medicare].

Significantly, the present case is atypical because it does not involve overbilling for services provided, and it does not involve billing for unnecessary services. In fact, the auditor testified that an audit of Atrium I revealed that Atrium I *underbilled* Medicare & Medicaid.

Jack Kahringer, an auditor for the United States Department of Health and Human Services, Office of Inspector General, testified that 28 PA Code 211.5 required that records of a health care facility be kept for a minimum of seven years after a resident's discharge or death. A similar federal regulation required proper maintenance of the records and deferred to the state time limitations. The regulation was read into the record. 42 C.F.R. 483.75(1).

Likewise, the standard of care articulated in 42 C.F.R. 483.15 was read into the record as follows:

> A. Quality of Life. A facility must care or keep residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

Finally, 42 C.F.R. 483.25 was read into the record as follows:

> A. Each resident must receive and the facility must provide the necessary care and services to attain the or maintain the highest practicable physical, mental, and psycho-social well being in accordance with the comprehensive assessment and plan of care.

Mr. Kahringer testified that between 1999 and 2003, Atrium I received the following payments from Medicare and Medicaid:

* $3,015,247 for Medicaid

* $11,774,452.68 for Medicare

* $14,789,699.68 for Medicare and Medicaid combined

Mr. Kahringer explained that Medicare and Medicaid payments accounted for 70% of Atrium I's revenues. He testified that he could have audited Atrium concerning Medicaid payments but did not. He explained the results of his audit as to Atrium concerning Medicare in the following manner:

> Q. So what did you find when you checked the Atrium records versus the bills that were submitted to Medicare?
>
> A. We took, I think there were 149 Medicaid (sic) claims. We were looking at the 2001

claims. Claims submitted in 2001. I think there was (sic) about one hundred forty nine claims . . .

Q. Did you find any errors in the documents that you looked at?

A. Yes.

Q. Can you recall, approximately, how many?

A. We found, we looked at 43 claims. Found about 48 errors.

Q. And what, if any, net effect, did those 48 errors have on the accuracy of the Medicare billing?

A. I think we determined that they actually under-billed for those claims by about $6,000.00.

Q. Was the actual figure some $6,069.37

A. Yes.

C. THE CASE DOES *NOT* INVOLVE THE FAILURE TO PROVIDE REQUIRED 2.7 HOURS OF DIRECT CARE FOR EACH RESIDENT

Mr. Kahringer read 28 PA Code 211.12(a) into the record as follows:

> A. Facility shall provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to meet the needs of all residents.

Mr. Kahringer testified that pursuant to 28 PA Code 211.12(i) the following was required:

> A. A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.

The government witness later read into the record parts of 42 C.F.R. 483.30, which also required "sufficient nursing and related services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident as determined by resident assessment and individual plans of care.

Mr. Kahringer testified as follows:

> A. We looked at the nursing staffing sheets maintained by an employee of Atrium Al

> Mangine, and that recorded the number of hours that each nurse worked per shift. There were three shifts in the day. And we looked at the census, patient census, to see how many patients were in the facility each day.
>
> . . . .
>
> A. We looked at a two week period. We looked at the records from October 1, 2001 through October 14, 2001.
>
> Q. What did you find in as far as the ratio is concerned?
>
> A. The 2.7 ratio was met each day.

Mr. Kahringer testified that he reviewed the staffing sheets and did not find any falsification.

Mr. Kahringer testified that he accepted the fiscal intermediary's statement (Veritus) that Ms. Bell and Warren Mason's salaries were reasonable and not excessive. He testified that the salaries paid to Ms. Bell and Mr. Mason had no effect on money paid by Medicare.

D. THE GOVERNMENT'S THEORY OF PROSECUTION

Because the prosecution had no evidence of overbilling, it proceeded to trial on the following theory of liability:

> PROSECUTOR: I will concede, Your Honor, that if that's all the evidence there was in this case, it would not be criminal because that would be talking about a civil case, administrative matters. What makes this case criminal and what makes it fit into the indictment and makes these statutes apply is the evidence that, by a systematic and continuous pattern and practice of records falsification, instituted by Martha Bell, these defendants concealed from the Department of Health the extent of the care deficiencies and, thereby, retained their certification to continue receiving Medicare and Medicaid payments. [Prosecution's argument during Rule 29 motion].

REASONS FOR GRANTING THE PETITION

Rule 10. Considerations Governing Review on Certiorari

Review on certiorari is not a matter of right, but of judicial discretion. A petition for writ of certiorari will be granted only for compelling reasons. The following, though neither controlling nor fully measuring the Court's discretion, indicate the character of the reasons the Court considers:

(a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of the Court's supervisory power;

(b) a state court of last resort has decided an important federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals;

> (c) a state court or a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court.

I. The Conviction For Medicare/Medicaid Fraud Must Be Reversed Because It Was Based On The Theory That False Statements Were Made To Maintain Medicare/Medicaid Certification, But A Medicare/Medicaid Certification Is Not Money Or Property Under The Reasoning Set Forth In *Cleveland v. United States*, 532 U.S. 12, 121 S. Ct. 365, 148 L. Ed. 2d 221 (2000)

18 U.S.C. § 1347 was modeled after the bank fraud statute which was modeled after the federal mail and wire fraud statutes; consequently, district courts have relied on the law interpreting the bank fraud statute and the mail and wire fraud statutes in interpreting the health care fraud statute. ***United States v. Mermelstein***, 487 F. Supp. 2d 242, 254 n.2 (E.D.N.Y. 2007).

The mail fraud, wire fraud, and health fraud statutes are limited to schemes to defraud the victim of money or property in the hands of the victim. ***McNally v. United States***, 483 U.S. 350, 360, 97 L. Ed. 2d 292, 107 S. Ct. 2875 (1987).

In the present case, the indictment charged a scheme to defraud Medicare/Medicaid of money. When the government's audit failed to reveal overbilling for services, the government's theory of the case morphed from a scheme to defraud Medicare/Medicaid of money into a scheme to maintain Medicare/Medicaid certification.

The conviction for health care fraud must be reversed because a Medicare/Medicaid certification is not property in the hands of the victim.

This Court has held that false statements in an application for a video poker license are not covered by the mail fraud statute because the license in the hands of the victim is not a property right. ***Cleveland v. United States***, 532 U.S. 12, 121 S. Ct. 365, 148 L. Ed. 2d 221 (2000) [Held that a state video poker license does not constitute property of the state under 18 U.S.C. § 1341].

For similar reasons, false statements made to maintain Medicare or Medicaid certification cannot be the foundation for a violation of the health care fraud statute because the Medicare/Medicaid certification is not a property right in the hands of the victim. Like ***Cleveland***, the certification is a regulatory device as opposed to a property right.

In sum, the conviction for health care fraud must be reversed because a scheme to defraud requires the object of the scheme be money or property in the hands of the victim. A Medicare/Medicaid certification is not money, property or a property right. As such a scheme to maintain Medicare/Medicaid certification is not criminalized by 18 U.S.C. § 1347.

II. Convictions For Making False Statements To Conceal Allegedly Substandard Medical Care Must Be Reversed Because The False Statements Were Not Material And Because The Statute And Regulations Do Not Provide A Clear Definition Of What Constitutes Substandard Medical Care

In the present case, the government established to the satisfaction of a jury that Martha Bell caused employees of Atrium I to make false statements in paperwork reviewed by state and federal regulators. The government established that some families were not satisfied with the level of care provided to their loved ones by Atrium I. Finally, the government established that 70% of Atrium I's revenues came from Medicare and Medicaid.

Even so, the government failed to connect the dots. The government failed to establish a nexus between the false representations, the allegedly substandard medical care, and the payments from Medicare/Medicaid. As such, the government failed to establish the false statements were "material."

This case was atypical because it was constructed around the novel premise that Ms. Bell, as a director and administrator of Atrium I, caused false representations to be made, which concealed an institutional failure to satisfy some as yet undefined standard of medical care for Alzheimer's patients. Yet, the statute and regulations speak in generalities and provide no path for a medical facility to follow when treating Alzheimer's disease. Consider the regulations.

42 C.F.R. 483.15 reads, in pertinent part, as follows:

> Quality of Life. A facility must care or keep residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

42 C.F.R. 483.25 reads, in pertinent part, as follows:

> Each resident must receive and the facility must provide the necessary care and services to attain the or maintain the highest practicable physical, mental, and psycho-social well being in accordance with the comprehensive assessment and plan of care.

Mr. Kahringer read 28 PA Code 211.12(a) into the record as follows:

> A. Facility shall provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to meet the needs of all residents.

Mr. Kahringer testified that pursuant to 28 PA Code 211.12(i) the following was required:

> A. A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.

The government witness later read into the record parts of 42 C.F.R. 483.30, which also required "sufficient nursing and related services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident as determined by resident assessment and individual plans of care."

Mr. Kahringer testified as follows:

> A. We looked at the nursing staffing sheets maintained by an employee of Atrium Al Mangine, and that recorded the number of hours that each nurse worked per shift. There were three shifts in the day. And we looked at the census, patient census, to see how many patients were in the facility each day.
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> A. We looked at a two week period. We looked at the records from October 1, 2001 through October 14, 2001.
>
> Q. What did you find in as far as the ratio is concerned?
>
> A. The 2.7 ratio was met each day.

Mr. Kahringer testified that he reviewed the staffing sheets and did not find any falsification.

The government presented witnesses who had loved ones in Atrium and who complained about the quality of care. However, Ms. Bell and Atrium presented witnesses who gave Atrium high marks for quality of care.

At bottom, the government's case was constructed around the prosecutor's subjective opinion that the care, services, and environment provided by Atrium I were substandard even though there was (and is) no fixed standard for the care of Alzheimer's patients except that each patient must receive 2.7 hours of direct care/day.

Here, the government presented no medical evidence connecting false statements to the substandard care of any particular resident. The failure to maintain adequate records is an administrative matter, and not a basis for a fraud prosecution absent a substantial connection between the misrepresentations, substandard care of the residents, and the payment of money for the care of the residents by Medicare or Medicaid. There was no such connection in this case. As demonstrated above, this was not a case of overbilling.

The government's theory of the case is not only contrary to ***Cleveland***, but also it is contrary to the principles articulated in ***Gonzales v. Oregon***, 546 U.S. 243, 126 S. Ct. 904, 163 L. Ed. 2d 748 (2006), where this Court stated that while the government has the right to set forth uniform standards for regulating health and safety, when it comes to the practice of medicine, the standards must be explicit. In the present case, there is a federal statute, and there is the CFR. There are state statutes and state regulations. The entire field is regulated to the logical extreme. Even so, neither the statute nor the regulations explicitly define a standard of care except to state that each patient must receive 2.7 hours of skilled nursing care. In this case, the audit trail indicates Atrium I satisfied this standard of care.

In ***Gonzales***, the Court recognized that the statutory term "legitimate medical purpose" is an airy generality, so subjective it is susceptible to varying interpretations and thus ambiguous. Likewise, the quality of care provisions set forth in 42 C.F.R. 483.15 and 483.25 are airy generalities, which are totally subjective and susceptible to varying interpretations, and at least as ambiguous as the provisions analyzed in ***Gonzales***.

Gonzales is factually distinguishable. Even so, the theory behind the case is relevant because it indicates that the government does not have the authority to criminalize medical care based on an ambiguous statute or regulation.

The Court stated, "Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes." 126 S. Ct. at 921.

III. The Decision Of The Court Of Appeals Conflicts With The Decisions Of This Court And Other Courts Regarding The Government's Obligation Not To Suppress Evidence Material To The Defense

United States v. Scheer, 168 F.3d 445, 452 (11th Cir. 1999) is a good explanation of the principles of ***Brady v. Maryland***, 373 U.S. 83, 83 S. Ct. 1194, 10 L. Ed. 2d 215 (1963) in the context of the failure to disclose impeachment information:

> In the case of impeachment evidence, the constitutional error may derive from the government's failure to assist the defense by disclosing information that might have been helpful in conducting cross-examination. *United States vs. Bagley*, 473 U.S. 667, 678, 105 S.Ct. 3375, 3381, 87 L.Ed.2d 481 (1985). In rejecting any distinction between impeachment evidence and exculpatory evidence in the *Brady* context, the Supreme Court has observed that "the jury's estimate of the truthfulness and reliability of a given witness may well be determinative of guilt or innocence, and it is upon such subtle factors as possible interest of the witness in testifying falsely that a defendant's life or liberty may depend." *Napue vs. Illinois*, 360 U.S. 264, 269, 79 S.Ct. 1173, 1177, 3 L.Ed.2d 1217 (1959)
>
> In *Hays vs. Alabama*, 85 F3d 1492 (11th Cir. 1996), we explicitly set forth the factors, as established by the Supreme Court in *Kyles*,

> that necessarily must guide our determination as to the materiality of evidence: First, "a showing of materiality does not require demonstration by a preponderance that disclosure of the suppressed evidence would have resulted ultimately in the defendant's acquittal," Id. at 1498 (quoting Kyles 514 U.S. at 434, 115 S.Ct. at 1566). "Thus, undisclosed evidence can require a new trial even if it is more likely than not that a jury seeing the new evidence would still convict." id. Second, a" defendant need not show there was insufficient evidence to convict in view of the suppressed evidence." Id. Third, there is no "harmless error" review of *Bagley* errors. Id. Fourth, "materiality is to be determined collectively, not item-by-item." Id.

Kyles v. Whitley, 514 U.S. 419, 131 L. Ed. 2d 490, 115 S. Ct. 1555 (1995) states that the analysis of "materiality" in connection with the non-disclosure of **Brady** material is to be viewed collectively, and not item-by-item. The petitioner does not have to show that he would have won the case but for the suppression of evidence.

Banks v. Dretke, 540 U.S. 668, 124 S. Ct. 1256, 157 L. Ed. 2d 1166 (2004) ruled that a criminal defense attorney can rely on the prosecutor to produce the evidence, and that he is not required to hunt for the exculpatory evidence.

Youngblood v. West Virginia, 547 U.S. 867, 126 S. Ct. 2188, 165 L. Ed. 2d 269 (2006) indicates that a Brady violation takes place when the government fails to turn over evidence known only to police investigators and not to the prosecutor.

Petitioner filed a Rule 33 motion alleging the prosecutor failed to provide discovery materials that could have been used by a skilled defense attorney to put the case in a different light.

Cheryl Bushmire testified that: she worked at Atrium I from 1996 until 2002; she was escorted out of Atrium because everything she did was wrong; she stepped down as unit manager because she could no longer obey Ms. Bell directives including filling holes in the MARS, TARS, ADLS, record reviews with buzz words including dehydration or specific items which could trigger reviews by the DOH.; she characterized the actions as unethical; records were falsified on a daily basis; documents or records were taken out and rewritten or destroyed and the unit managers had to do it; the only two people who damaged records were Peg Hirsch and Kelly Davies.

Bushmire was directed to January 2001 and a pending decertification of Atrium. She testified there were matters that had to be cleaned up and that Ms. Bell wanted her to fix up documents.

Bushmire testified that she was a unit manager in 2000 and 2001 and that on a daily basis in 1999, unit managers went to the board room and falsified documents. In January, 2001, she and Peg Hirsch were called to the boardroom by Ms. Bell and falsified records.

On cross-examination, in attempting to impeach Cheryl Bushmire, the defense attorney made use of various inconsistent statements that Ms. Bushmire made to the authorities.

Obviously, the testimony of Ms. Bushmire was crucial to the prosecution's case because it was the bridge between the false statements and Ms. Bell.

As a result of the search conducted by the federal government and the search conducted by the District Attorney of Allegheny County, all of the records and documents pertaining to Atrium I were in the possession of the federal or state officials. Some of the records were destroyed by flood damage while in control of the government.

After trial, defense counsel became aware of certain statements of Ms. Bushmire that contradicted her testimony at the trial. For example, Bushmire's statement dated January, 2001 establishes that IO sheets were missing, nursing reports, 24 hour reports, crossed-out lab notations. Ms. Bushmire accused Robin Balding of doing these things. Specific reference is made to certain individuals tampering with files and records without reference to Ms. Bell.

On January 1, 2001, Kelly Davies wrote a statement contrary to her trial testimony. At trial, she blamed the false statements and records on Martha Bell. In prior statements, she placed the blame on disgruntled employees.

The documents were material because they could have been used to weaken the government's case by impeaching the government's witnesses who blamed Martha Bell for the false statements and destruction of records.

CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT FILED JUNE 6, 2008

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Nos. 06-4648, 4649

UNITED STATES OF AMERICA

v.

MARTHA BELL,

Appellant in No. 06-4648.

ATRIUM I NURSING AND REHABILITATION CENTER,

Appellant in No. 06-4649.

On Appeal from the United States District Court
for the Western District of Pennsylvania
(D.C. No. 04-cr-0212)
District Judge: Honorable Terrence F. McVerry

Submitted Under Third Circuit LAR 34.1(a)
June 3, 2008

Appendix A

Before: FISHER, JORDAN, *Circuit Judges*, and YOHN*, *District Judge.*

Filed June 6, 2008

OPINION OF THE COURT

JORDAN, *Circuit Judge.*

Martha Bell appeals from the October 31, 2006 judgment of conviction entered by the United States District Court for the Western District of Pennsylvania, after a jury found her guilty of health care fraud, in violation of 18 U.S.C. § 1347, and making false statements relating to health care matters, in violation of 18 U.S.C. § 1035(a)(2). We will affirm.

I. Background

On August 24, 2004, an eleven count indictment was filed against Atrium I Nursing and Rehabilitation Center ("Atrium") and its operator, Bell, charging them with one count of health care fraud (Count 1) and ten counts of false statements relating to health care matters (Counts 2 through 11). *United States v. Bell,* No. 04-212, 2006 WL 952214, at *1 (W.D.Pa. Apr.12, 2006) ("*Bell I*"). A jury trial began on July 19, 2005, and on August 24, 2005, the jury "rendered a unanimous verdict

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* Honorable William H. Yohn, Jr., Senior Judge, United States District Court for the Eastern District of Pennsylvania, sitting by designation.

as to each defendant." *Id.* Bell was found guilty on Counts 1-6, 8, 10, and 11, and Atrium was found guilty on all counts. *Id.* On November 18, 2005, the District Court denied Atrium's and Bell's motions for judgment of acquittal, and, on April 12, 2006, denied their motions for reconsideration of the November 18th decision. *Id.* at *2. On May 16, 2006, the Court denied Atrium's and Bell's motions for a new trial based on the government's alleged violations of *Brady v. Maryland*, 373 U.S. 83, 83 S.Ct. 1194, 10 L.Ed.2d 215 (1963). *U.S. v. Bell*, No. 04-212, 2006 WL 1330200, at *1 (W.D.Pa. May 16, 2006) ("*Bell II*").

On October 27, 2006, Atrium was sentenced to five years probation and a fine of $490,000. Bell was sentenced to sixty months of incarceration followed by a term of supervised release of three years and a fine of $50,000. The Court entered the judgments of conviction and sentence on October 31, 2006. This appeal followed.[1]

1. Atrium was dissolved by a December 26, 2007 Order of the Court of Common Pleas of Allegheny County, Pennsylvania. On January 9, 2008, that Court appointed Robert B. Stein, Esquire, as Atrium's receiver. Atrium had filed an appeal but, by letter dated May 9, 2008, Mr. Stein stated on Atrium's behalf that, "the appeal in [this case] is to be withdrawn." We therefore treat Atrium's appeal as abandoned and address only Bell's arguments.

II. Discussion[2]

Bell argues that there was insufficient evidence presented at trial to convict her of health care fraud. She also challenges the sufficiency of the evidence as to her conviction for making false statements relating to health care matters as set forth in Count 3 of the indictment. Finally, Bell argues that the District Court erred in failing to grant her motion for a new trial based on the government's alleged failure to comply with its disclosure obligations under *Brady*.

A. Count 1

Bell first challenges the sufficiency of the evidence as to her conviction for health care fraud (Count 1 of the indictment). She argues that the government failed to demonstrate the "execution of a scheme or artifice to

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2. The District Court had jurisdiction pursuant to 18 U.S.C. § 3231. We have jurisdiction pursuant to 28 U.S.C. § 1291. We review challenges to the sufficiency of the evidence "in the light most favorable to the government, and will sustain the verdict if any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt." *United States v. Hodge*, 321 F.3d 429, 439 (3d Cir.2003) (citation omitted). When a motion for a new trial is based on a *Brady* claim, which "presents questions of law as well as questions of fact, we will conduct a *de novo* review of the district court's conclusions of law as well as a clearly erroneous review of any findings of fact." *United States v. Pelullo*, 399 F.3d 197, 202 (3d Cir.2005) (internal quotation marks and citations omitted).

defraud" as required by 18 U.S.C. § 1347.[3] Bell says the evidence demonstrates only that she "violated general administrative regulations," but that it does not establish criminal conduct. (Appellant's Brief at 38.)

We disagree. Viewing the evidence in the light most favorable to the government, the record amply supports that Bell knowingly engaged in a scheme with the specific intent to defraud Medicare and Medicaid in connection with both the delivery of and payment for health care benefits, items, and services. For example, Bell directed Atrium's employees to falsify records so that they did not accurately reflect the deplorable conditions at Atrium.[4] The falsified records were then

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3. The statute provides:Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

> (1) to defraud any health care benefit program; or
>
> (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both.... 18 U.S.C. § 1347.

4. A detailed recounting of the depredations Bell inflicted on Atrium residents is unnecessary. Suffice it to say that the accounts are genuinely heartbreaking—accounts of helpless, elderly and infirm residents left to lie in their own waste, one

(Cont'd)

provided to the Pennsylvania Department of Health ("DOH") for the specific purpose of deceiving it into believing that Atrium complied with applicable regulations, so that Atrium would maintain its certification under Medicare and Medicaid and, hence, the flow of government money. Bell was properly found guilty of health care fraud "based upon a scheme to falsify records" that she used "in an attempt to conceal from state and federal regulatory agencies the substandard care which was being provided to residents at Atrium." *Bell I*, 2006 WL 952214 at *2. Sufficient evidence supports Bell's conviction on Count 1 of the indictment.

B. Count 3

Bell also argues that there was insufficient evidence presented at trial to convict her of Count 3 of the indictment. Count 3 charged Bell with making false statements in connection with Mabel Taylor's death

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(Cont'd)

with an empty oxygen canister, another with undissolved medication in her mouth for hours, another with bruises and open sores, and so on and on, all being left with no protection from the violent outbursts of other senile and understandably frustrated residents, and this while Bell lined her pockets and left vendors unpaid. The temporary administrator who took over management of the facility from Bell indicated that, though he had taken over other problem facilities in the past, he had never seen anything like the conditions he encountered at Atrium. (Appendix at 2905.)

while she was a resident at Atrium, in violation of 18 U.S.C. § 1035(a)(2).[5]

On the evening of October 25, 2001, Taylor wandered into Atrium's courtyard and could not get back into the building because the doors were

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5. The statute provides:

> (a) Whoever, in any matter involving a health care benefit program, knowingly and willfully . . .
>
> (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services, shall be fined under this title or imprisoned not more than 5 years, or both.
>
> (b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

18 U.S.C. § 1035(a)(2).

The term "health care benefit program" is defined as "any public or private plan or contract, affecting commerce, under which any medical benefit, item or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." 18 U.S.C. § 24(b).

malfunctioning. She was found dead in the courtyard at 4:00 a.m. on October 26, 2001. On October 29, 2001, Bell asked Harold Whipkey, an Atrium employee, to prepare a written statement that he saw Taylor inside on the night that she died. Whipkey complied and prepared two statements to that effect. However, Bell knew full well that Whipkey's statements were false and that he was actually at a bar on the evening that Taylor died.

Bell argues that Whipkey's false statements did not "involv[e] a health care benefit program" because they were made "in relationship to the police investigation and had nothing to do with health care or a health care benefit program." (Appellant's Brief at 49.) However, Whipkey's false statements were provided to the DOH in connection with its abuse investigation after Taylor's death, thereby implicating Atrium's receipt of Medicare and Medicaid funding. Further, Atrium was a qualifying "health care benefit program" because it was receiving funds under Medicare and Medicaid, and Whipkey's false statements obviously related to care given—or not given—by Atrium. As the government points out, the "false statements at issue concerned health care services that had been provided to Ms. Taylor at Atrium on the night of her death. Thus, the false statements were in fact made in connection with the delivery of health care services, as is required to sustain a conviction under § 1035(a)(2)." (Appellee's Brief at 53.) Viewing the evidence in the light most favorable to the government, it is clear that there is sufficient evidence to sustain Bell's conviction on Count 3 of the indictment.

Appendix A

C. Alleged Brady Violations

As for the *Brady* violations that Bell alleges, she makes essentially the same arguments on appeal as she did to the District Court in support of her motion for a new trial. She argues that the government withheld correspondence with United States Senator Rick Santorum that she herself authored and received on Atrium's behalf. She also contends that certain out-of-court statements by two government witnesses were not disclosed prior to trial.

In denying Bell's motion for a new trial, the District Court applied the appropriate legal standard, which it summarized as follows:

> [To] establish a *Brady* due process violation, a defendant must show that (1) evidence was suppressed; (2) the suppressed evidence was favorable to the defendant; and, (3) the suppressed evidence was either material to guilt or to punishment. . . . However, the government is not obliged under *Brady* to furnish a defendant with information which he already has or, with any reasonable diligence, he can obtain himself.

Bell II, 2006 WL 1330200 at *2 (citations and internal quotation marks omitted). The Court then "f[ound] and rule[d] that the correspondence which . . . Bell sent to and received from Senator Santorum is simply not *Brady* material" because "Bell was the sender and

receiver of both of these letters[,]" and "there is no indication or allegation that these letters were either sent to or in the possession of the government. . . ." *Id.* The Court concluded that Bell thus "failed to establish that" the correspondence between herself and Senator Santorum was "suppressed within the meaning of *Brady*," and she, "therefore, failed to establish a *Brady* violation." *Id.* There is no error of fact or law in that conclusion.

The District Court also "f[ound] and rule[d] that [Bell] failed to establish that the alleged statements of [the government witnesses] were suppressed within the meaning of *Brady* " because there was no "evidence to support [Bell's] claim that the government had possession, either actual or constructive, of [those] statements . . . and failed to provide same to [Bell]. Accordingly, [Bell has] failed to establish a *Brady* violation." *Id.* at *3. Again, the District Court did not err as a matter of fact or law in reaching that conclusion.

III. Conclusion

For the foregoing reasons, Bell's judgment of conviction will be affirmed.